

# **EXHIBIT 12**

**DECLARATION OF DR. DAVID F. KOTZ**

I, David F. Kotz, declare as follows:

1. I am the Provost at Dartmouth College (“Dartmouth”) in Hanover, New Hampshire. I have held that position since 2021. I am also the Pat and John Rosenwald Professor of Computer Science, and a researcher who has held funding from several federal agencies, including the National Institutes of Health (“NIH”). I have been on the faculty at Dartmouth since 1991, and I make this declaration in support of Plaintiffs’ Complaint and Motion for a Temporary Restraining Order.

2. As Provost, I have personal knowledge of the contents of this declaration, or have knowledge of the matters based on my review of information and records gathered by Dartmouth personnel (including in the Office of Sponsored Projects), and could testify thereto.

3. Dartmouth is a nationally recognized research institution and has “R1” status on the Carnegie Classification of Institutions of Higher Education, which indicates “very high research activity” and recognizes Dartmouth’s significant contribution to advancing scientific discoveries that have tangibly benefitted the population of the US and the World.<sup>1</sup>

4. In fiscal year 2024, Dartmouth received over \$178 million in external research funding, of which \$137 million was awarded by the federal government. Over \$97 million of that federal funding was awarded specifically by the NIH.

5. Dartmouth’s Geisel School of Medicine (“Geisel”) is the only medical school in the State of New Hampshire. Geisel, its primary clinical affiliate Dartmouth Health, and the

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<sup>1</sup> <https://carnegieclassifications.acenet.edu/institution/dartmouth-college/>

White River Junction VA Medical Center together form the Dartmouth-Hitchcock Medical Center, which houses the only Level 1 Trauma Center between Burlington, VT, Portland, ME, and the Boston area.

6. The federal funding that Dartmouth receives from NIH, largely through Geisel and Dartmouth's Thayer School of Engineering ("Thayer"), supports critical scientific and medical research programs aimed at improving health outcomes. Examples of these programs include:

- a. The Dartmouth Cancer Center Support Grant, which funds groundbreaking scientific initiatives in cancer immunology, cancer engineering, biological mechanisms, experimental therapeutics, molecular epidemiology, health care delivery science and cancer prevention and control. The program includes an enhanced emphasis on translating research discoveries to hard-to-reach populations, especially those within Dartmouth's rural two-state catchment area of New Hampshire and Vermont. Research from the Dartmouth Cancer Center led to the first cancer immunotherapy, which is now used worldwide and is credited with providing nearly 1 million years of extended healthy lifespan to cancer patients;
- b. The Center for Technology and Behavioral Health at Dartmouth ("CTBH"), recognized as an NIH P30 "Center of Excellence," which is dedicated to developing clinical-grade digital therapeutics that enhance access to and quality of behavioral healthcare and tools that have been shown to improve patient outcomes while reducing costs. Research done at CTBH led to the first FDA-approved digital therapeutic approach to treating substance use disorder, directly

addressing the disproportionate level of overdose deaths in the state of New Hampshire;

- c. The Center for Molecular Epidemiology, an NIH Center for Biomedical Research Excellence, seeks to translate cutting-edge scientific approaches to enhancing human health discoveries, including new ways to examine the contaminant exposure risk in vulnerable rural populations. This research grant supports the New Hampshire Birth Cohort Study, with the goal of enhancing the health of children, particularly those in rural areas, for generations to come;
- d. The SYNERGY Clinical and Translational Science Institute, which, led by faculty at Geisel and Thayer in partnership with Dartmouth Health, is the holder of the only NIH Clinical and Translational Science Award in Northern New England, with a mandate to advance rural healthcare; and
- e. The Dartmouth Cystic Fibrosis (“CF”) Research Center, one of only seven NIH-funded CF Research and Translation Centers nationwide, which has developed innovative strategies to extend lifespans and improve CF care across the country.

7. Critically, the cost of carrying out these and other NIH priority research activities is only partially covered by “direct costs” that Dartmouth is able to charge to federal grants supporting research. Dartmouth invests significant resources to construct, operate, and maintain purpose-built laboratory facilities, purchase and maintain highly advanced research equipment, and ensure research compliance with numerous federal mandates. A portion of Dartmouth’s investment is reimbursed through specifically negotiated “indirect costs” to sustain this critical research infrastructure, without which these research programs would not be possible.

8. By way of example, Dartmouth has invested in and maintains approximately 820,000 square feet of space for researchers, along with additional space for shared research resources. New investments are made every year to upgrade this space, which is necessary for continuing to advance leading-edge research. For example, in 2022, Dartmouth opened two new research-intensive buildings, including a new Engineering and Computer Science Complex (“ECSC”). The ECSC houses several dozen faculty, many funded by NIH to address critical healthcare challenges, including the development of tools to evaluate the antibody response in disease states ranging from infection to cancer, to aid in therapeutic antibody and vaccine design and development, and to explore the growing challenges of student mental health on college campuses. These new facilities, which together added 100,000 square feet to Dartmouth’s available research space, represent institutional expenditures of over \$310 million.

9. In addition to Dartmouth’s investment in new facilities to support research advances, the institution must also maintain its existing research infrastructure in order to deliver on federally-funded research. As reported on our most recently completed National Science Foundation Survey of Science and Engineering Research Facilities, Dartmouth spent \$17 million of its own funds for the repair and renovation of research facilities in fiscal years 2022 and 2023, and anticipates spending another \$14 million in institutional funds to maintain these existing facilities in fiscal years 2024 and 2025. These investments, to which Dartmouth has already committed, have been made specifically in reliance on our ability to recover a portion of these expenses through the negotiated indirect costs rate with federal agencies like the NIH.

10. Direct negotiations and detailed audits with the federal government in 2022 resulted in the setting of a predetermined rate that Dartmouth had expected in good faith would be applicable through 2029. This rate agreement represents the culmination of a lengthy process

(as specified by 2 CFR 200 Part 200 Appendix III), which required Dartmouth to provide detailed financial data and schedules in accordance with the government's standard format and process for rate proposals including cost pool schedules and a reconciliation to Dartmouth's financial statements. The proposal itself was 254 pages and was certified by a senior finance officer and accompanied by audited financial statements. The cognizant audit agency team reviewed the proposal in accordance with procedures prescribed by the Department of Health and Human Services during a process which took approximately a year.

11. If the NIH's proposed cut to a flat 15% rate across the board comes to pass, Dartmouth's specifically negotiated and agreed indirect-cost recovery rate would be slashed by more than 75%. This would result in a \$24 million shortfall as compared to amounts received to support critical research infrastructure in fiscal year 2024.

12. It would be impossible for Dartmouth to absorb such a significant shortfall without making cuts in research programs and related key areas of campus operations. Such cuts would certainly result in a hiring freeze on faculty, postdoctoral associates, and graduate students, directly impacting our ability to conduct advanced research in the public interest and train the next generation of research scientists. These cuts would have the immediate effect of reducing the number of good-paying jobs available in our local community, with knock-on effects impacting the retail and service-sector businesses in the area.

13. Dartmouth would also likely need cut back on the core support facilities and services that we provide to our existing researchers, hampering their ability to do critically important research in an efficient, effective, safe, and secure manner. In the short term, facility projects might be canceled, institutional purchases of specialized research equipment would be put on hold indefinitely, and laboratory renovations would pause. In the longer term, investment

in the renewal of scientific facilities would stop altogether as a necessary step to absorb the financial impact of this new policy application, and where unreimbursed costs are required to remediate a safety issue or otherwise resolve a compliance concern, the institution would be forced to offset these expenses by effecting cuts in other areas, perhaps by implementing significant layoffs. These decisions would be devastating not only to the Dartmouth community but also to the local economy.

14. The world's best scientists will not move to (or stay at) universities where they are not able to conduct world-class research. The reality of this shortfall and the cuts it would necessitate would reduce the amount available for new faculty "start-up" packages, which are required for junior investigators to set up their laboratories and jump start their own new research programs. Our inability to sustain and expand our scientific programs would make it more difficult to attract research-minded physicians to the Dartmouth-Hitchcock Medical Center, a major tertiary care referral site for patients across northern New England. This would inevitably reduce the number of highly-trained specialist clinicians available to support the health needs of the (largely rural) population of New Hampshire and Vermont and give them the care that they deserve, including participation in clinical trials and the receipt of cutting-edge treatments that would no longer be accessible to those without the ability to travel for several hours to a major urban center.

15. Notably, while Dartmouth is fortunate to have a significant endowment, we are not able to make up the difference in operating budget that this massive reduction in indirect-cost support would create by either increasing the endowment distribution or invading endowment principal. The purpose of the endowment is to provide maximum sustainable financial support to Dartmouth to serve its mission in perpetuity. Core to the endowment's purpose is balancing the

interests of current and future generations of Dartmouth students. Maintaining the inflation-adjusted value of the endowment underpins this concept of intergenerational equity.

16. Dartmouth's endowment consists of nearly 6,700 individual funds, each with specific agreements and restrictions. Of Dartmouth's total endowment, 78% is restricted to specific programs and uses and is therefore unavailable to fund a general operating shortfall.

17. The unrestricted portion of Dartmouth's endowment is already committed to support a variety of initiatives including financial aid, student experience, professorships, infrastructure, and enabling support for other areas of the institution. It is also not possible to simply increase the endowment distribution rate because it is limited by standards of prudence under the New Hampshire Uniform Prudential Management of Institutional Funds Act (UPMIFA) and subject to the active oversight of the Charitable Trusts Unit of the State Attorney General's Office.

18. And even if it were consistent with standards of prudential management, increasing the spend of unrestricted money from Dartmouth's endowment would very quickly cripple the institution's ability to fulfill its overall mission, leaving Dartmouth with only restricted funding and no flexibility to allocate resources to research or other unfunded core academic initiatives.

19. In sum, the NIH's actions to limit Dartmouth's recovery of the very real and highly significant investments it has made and will continue to be required to support its research infrastructure will have adverse impacts not only on the institution but on our local community, northern New England, and the largely rural patient population for which accessing world-class, groundbreaking treatments need not mean leaving home.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on February 10, 2025, at Hanover, New Hampshire.

/s/ David F. Kotz

David F. Kotz, Provost